Gary Carmassi DMD
412 367-4515

Medical History and Consent

List any medications you are taking:

Medication	Dosage/Freq.	Prescriber	Reason
1.			
2.			
3.			
4.			
5.			
6.			

List any surgeries or hospitalizations you have had:

Date (year)	Surgery	Surgeon	Reason

List and detail any medical condition or history not listed above:

_____
_____
_____
_____

Primary Physician's Name: _____ **Phone #:**_____ **Pharmacy #**_____

Are you under the care of other physicians? If so, please list:

Physician	Phone #	Reason

GENERAL CONSENT TO DIAGNOSE AND TREAT: The undersigned hereby authorizes Gary Carmassi DMD to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize Gary Carmassi, DMD to perform any and all forms of treatment, medication, and therapy that may be necessary and further consent that Gary Carmassi, DMD choose and employ such assistance as deemed necessary. I understand that the use of local anesthetics agents embodies certain risk and consent to their use of deemed appropriate by Gary Carmassi, DMD. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/ the patient's health. It is my responsibility to inform the dental office of any change in medical health or status.

FINANCIAL CONSENT: I understand that responsibility for payment of services provided in this office for myself and my dependent(s) is mine, due and payable at the time services and rendered. I understand that I am responsible for any portion of fees for services rendered not covered by my dental insurance (if any). I further consent to and agree to pay a 1 ½% finance charge (18% annually) that will be applied to any balance over 30 days. I acknowledge that I am responsible for all fees necessary to collect my account. I authorize Gary Carmassi, DMD and his staff to verify insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits payable to him, and to handle any necessary claim appeal(s) on my behalf.

Consent (adult):

Name of patient _____ _____ **Date**_____
Signature of Patient

Consent (for a minor child):

Name of Parent/Guardian _____ _____ **Date**_____

Notice of Privacy Practices (Below)
Patient privacy is important to our practice. We are required by law to maintain the privacy of Protected Health Information ("PHI") and to provide individuals with notice of our legal duties and privacy practice with respect to PHI. By signing below you are acknowledging receiving notice of our practice policies and your rights regarding PHI. I allow release of pertinent medical records to my insurance company (if applicable) and my other medical providers.

_____ **Date**_____
Signature of Patient